MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

STREAMLINED RENEWAL FORMAT

1. The State of Connecticut requests a 5-year renewal of its home and community based waiver, number 0302.

2. ***Services***. All services in the renewed waiver are the same as those described in the original waiver (as amended).

   a. ____ Yes.

   b. __x__ No. The following services are removed from the renewal request. (Changed pages from the waiver document and appendices are attached.)

      1) Day Habilitation
      2) Family Training

   Services Removed:

   a. ____ The following services are now available in at least that amount, duration and scope under the state plan.

   b. __x__ The following services were not utilized under the original waiver:

      Day Habilitation

   Services Changed or Added. (Changed pages from the waiver document and appendices are attached.)

   c. __x__ The State requests the following new services or changes in service definitions, standards, or provider qualifications:

      1) Case Management service definition has been revised to clarify under what circumstances this service is purchased
      2) Cognitive Behavioral Programs service definition has been revised to clarify the provider's role within the context of the person-centered team and to incorporate the provisions of Family Training
      3) Community Living Support Services definition clarified to state that providers may provide incidental hands-on care in the provision of this service if acceptable to the consumer and provider

4) Companion service definition clarified to state that providers may provide incidental hands-on care in the provision of this service if acceptable to the consumer and provider
5) Homemaker service description revised to clarify that this service is available to a consumer who either does not choose to perform or can not learn such skills
6) Pre-Vocational Services - removed transportation from service description
7) Supported Employment - removed transportation from service description
8) Specialized Medical Equipment – language change in provider type from "Vendors who sell medical communication, *adaptive items* and supplies and/or DME" to " . . . *assistive devices* . . ."

3. ***Eligibility.*** All eligibility requirements and procedures described in the original waiver will remain in effect under the renewed waiver.

a. __x__ Yes.

b. ___ No. (Changed pages from the waiver document and appendices are attached.)

4. ***Assurances.*** All assurances and information in the approved waiver as required by 42 CFR 441.302(a) - (f) remain in effect, including all amendments approved by CMS.

a. __x__ Yes, with no changes.

b. ____ Yes, but with the following changes:

____ Provider qualifications (including licensure/certification) are different. The revised standards are reflected in changed pages from the waiver document and appendices, attached.

____ Changes in level of care assessment process, team, and/or instrument. Changed pages from the waiver document and appendices, as well as copies of revised forms (if applicable) are attached.

____ Changes in care planning process, team, and/or instrument. Changed pages from the waiver document and appendices, as well as copies of revised forms (if applicable) are attached.

____ Other. Changed pages from the waiver document and appendices, as

well as copies of revised forms (if applicable) are attached.

5. Per capita expenditure estimates, consistent with 42 CFR 441.303(f) are attached for each year of the renewed waiver. The state has used Appendix G of the Streamlined Application Format to prepare these estimates. These data are consistent with data supplied to and accepted by HCFA on form 372, except where noted and fully explained.

6. Documentation is attached to support the conclusion that the state has taken appropriate corrective action to resolve problems identified through state or Federal monitoring activities, or through the independent assessment of the original waiver.

   a. __x_Yes. The State has instituted a system of faxing plan revisions to appropriate staff and concurrently to its fiscal intermediary immediately upon approval.

   b. ____ No. There are no outstanding problem areas in this waiver. Corrective action is not necessary.

7. This document, together with the original waiver and all amendments approved by CMS, constitutes the state's request for renewal of its home and community based services waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all requirements set forth in the waiver, as amended and renewed, and certifies that any further modifications to the waiver request will be made in writing and submitted by the State Medicaid agency. Upon approval by CMS, this waiver renewal request will serve as the State's authority to provide home and community based services to the target group under its Medicaid plan. Any proposed changes to the approved renewed waiver will be formally requested by the State in the form of waiver amendments.

8. The State assures that all material referenced in this waiver renewal application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

9. The State chooses to perform an independent assessment of its renewed waiver, as permitted by 42 CFR 441.303(g), for the period of the renewal. This assessment will evaluate the quality of care provided, access to care, and cost-neutrality of the waiver.

   __x__ Yes ____ No

10. The State requests an effective date of January 1, 2002.

11. The State contact person for this waiver renewal request is:

Name: Sylvia Gafford-Alexander
Title: Acting Director, Social Work and Prevention Services
Tel: 860-424-5058
Fax: 860-424-5091
E-mail:*sylvia.gafford-alexander@po.state.ct.us*

12. Signature:

Print Name:

Title:

Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

__x__ The waiver will be operated by the Division of Social Work and Prevention Services, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this

waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _x_ Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1._____Yes 2._____No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1._____Yes 2._____No

__x__ Other Service Definition (Specify):

See Attachment B-1 for explanation

b._x_ Homemaker:

_x_ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such

standards of education and training as are established by the State for the provision of these activities.

___X___ Other Service Definition (Specify):
This service can be purchased when the individual is not able to or does not choose to perform this function for him or herself, and independent living skills training is not indicated for this purpose.

c._____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d.___x___ Personal care services:

___x___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

__x__ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

__x__ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

__x__ Case managers

__x__ Other (Specify):
The consumer or another individual designated to act in the consumer's behalf when cognitive impairments prohibit the consumer from providing supervision of his/her own personal care

3. Frequency or intensity of supervision (Check one):

__x__ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services (Check one):

__x__ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in

service definition or provider type from the services to be offered under the waiver.

___x___ Other service definition (Specify):

In addition to the previously-stated conditions, the waiver will not fund services provided by the following parties: an informal caregiver who has been providing care free-of-charge to the individual; the individual's conservator or any member of the conservator's family.

e.___x___ Respite care:

___x___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_____ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s) (Check all that apply):

___x___ Individual's home or place of residence

_____ Foster home

_____ Medicaid certified Hospital

_____ Medicaid certified NF

_____ Medicaid certified ICF/MR

_____ Group home

_____ Licensed respite care facility

_____ Other community care residential facility approved by the State that its not a private residence (Specify type):

_____ Other service definition (Specify):

f._____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1._____Yes 2._____No

_____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. x Habilitation:

x Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____ Day habilitation: assistance with

acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___x___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported

employment programs).

Check one:

_____ Individuals will not be compensated for prevocational services.

__x__ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

_____ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation

Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

X Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not

otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1._____Yes 2.___x___No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service

is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. x Environmental accessibility adaptations:

x Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other service definition (Specify):

i._____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. x Transportation:

x Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Prior to requesting waiver transportation in the Service Plan, the waiver participant and administrative coordinator must explore all reasonable means of having this service provided informally, or through the existing public transportation system.

x Other service definition (Specify):
Transportation may be provided by a family member between home and the vocational setting when transportation is not otherwise available and it is the most cost-effective option.

k. x Specialized Medical Equipment and Supplies:

x Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

_____ Other service definition (Specify):

l. x Chore services:

x Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

m. x Personal Emergency Response Systems (PERS)

x PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

n. x Adult companion services:

x Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

x Other service definition (Specify):
The provision of companion services may include cuing and/or incidental hands-on assistance with activities of daily living if acceptable to the consumer and provider, provided it is of a non-medical nature.

o._____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

p._____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (Specify):

q._____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or

cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

Other service definition (Specify):

r._____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and

services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed ___). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the

discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

_____ Home health care

_____ Physical therapy

_____ Occupational therapy

_____ Speech therapy

_____ Medication administration

_____ Intermittent skilled nursing services

_____ Transportation specified in the plan of care

_____ Periodic nursing evaluations

_____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. x Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Community Living Support Services (CLSS):Individualized services designed to support the waiver participant's ability to live in the community. CLSS provide supervised living in a residence and up to 24 hour support services, for as many as three individuals. The services provided under a CLSS consist of supervision of and assistance with an individual's self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, problem-solving skills, money management and ability to maintain a household if acceptable to the consumer and provider. Such assistance may include incidental hands-on care if acceptable to the consumer and provider. These services are provided in the residence and in the community. The CLSS provides overnight supervision.

A waiver participant who receives CLSS will not be precluded from attending or participating in any type of service or program in the community that is designated in the participant's plan. When a waiver participant chooses, or when his/her ability to live more independently improves, the CLSS provider will work with the waiver participant and the Department of Social Services' social worker to develop and implement a plan which results in the waiver participant's living more independently in the community.

CLSS differs from Independent Living Skills Training in that CLSS provides for supervision of and assistance to the individual for up to 24 hours per day. Independent Living Skills Training is purchased on an hourly basis and provides assessment and instruction in specific skills by implementing strategies identified in the plan of care. For example, it is possible for a waiver participant to receive ILST to learn how to feed himself. Once the individual has learned this task, (s)he may need CLSS to supervise meals to avoid aspiration.

All Community Living Support Services must be documented in the service plan and provided by agencies approved as providers of this waiver service. Provider qualifications are specified in Appendix B-2.

Medicaid funding of this service is for services only; no portion is allocated for housing costs (e.g., rent, food, room or board).

Cognitive/Behavioral Programs: Individual interventions designed to decrease the waiver participant's severe maladaptive behaviors which, if not modified, will interfere with the individual's ability to remain integrated in the community. Cognitive/Behavioral Programs consist of a comprehensive assessment of deficient cognitive and maladaptive behavior(s); development of a structured cognitive/behavioral intervention plan which has as its primary focus the teaching of socially appropriate behaviors; the elimination of maladaptive behaviors through the development and implementation of cognitive compensatory strategies; implementation of the plan; ongoing or episodic training and supervision of the waiver

participant, family members and caregivers concerning treatment regimens, cognitive and behavioral strategies and interventions and use of equipment specified in the plan of care, and periodic reassessment of the plan. Assistance to providers in implementing participant-specific interventions is also a component of Cognitive/Behavioral Programs. This service is performed within the context of the individual's person-centered team in concert with the DSS social worker, acting as administrative case manager. The service may be provided in the waiver participant's home or in the community in order to reinforce the training in a real life situation.

All Cognitive/Behavioral Programs must be documented in the Service Plan and provided by individuals or agencies approved as a provider of this waiver service. Provider qualification are specified in Appendix B-2.

Home-Delivered Meals: Preparation and delivery of meals for adults who are unable to prepare or obtain nourishing meals on their own or when the individual responsible for this activity is temporarily absent or unable to manage meal preparation. Meals provided will not constitute a full nutritional regiment(i.e., 3 meals a day).

The necessity of Home-Delivered Meals must be documented in the service plan and provided by agencies approved as providers of this waiver service. Qualifications of providers of this service are specified in Appendix B-2.

Independent Living Skills Training and Development: Individually designed services to improve the ability of the waiver participant to live as independently as possible in the community. ILST is provided on a one-to-one basis in both the waiver participant's residence and in the community, in the environment and situation which results in the greatest positive outcome for the waiver participant. This service is provided in the "real world"(e.g., in the waiver participant's kitchen rather than in an agency's kitchen) because of the difficulty many waiver participants experience in transferring or generalizing knowledge and skills from one situation to another.

Independent Living Skills Training and Development includes assessment and training of an individual with

self-care, which may include hands-on training for the purpose of teaching specific skills, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility and community transportation skills, carrying-out strategies developed by the cognitive behaviorist to reduce/eliminate maladaptive behaviors, problem-solving skills, money management and ability to maintain a household.

This service differs from Community Living Support Services in that it provides assessment and instruction in specific skills by implementing strategies identified in the plan of care, rather than providing supervision of and assistance to the individual. This service is purchased on an hourly, rather than a daily, basis by individuals or agencies approved as providers of this waiver service. Provider qualifications are specified in Appendix B-2.

Substance Abuse Programs: Individually designed interventions to reduce/eliminate the use of alcohol and/or drugs by the waiver participant which may interfere with the individual's ability to remain in the community if not dealt with effectively. Substance Abuse Programs are provided in an outpatient congregate setting or in the waiver participant's community and include the following: an in-depth assessment of the inter-relationship between the individual's substance abuse and brain injury; a learning/behavioral assessment; development of a structured treatment plan; implementation of the plan; ongoing education and training of the waiver participant, his/her family members, caregivers and all other service providers around participant-specific sequelae; individualized relapse strategies; periodic reassessment of the plan and ongoing support. The plan may include both group and individual interventions and reflects the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with traumatic brain injury. Linkages to existing community-based self-help/support groups such as Alcoholics Anonymous or secular organizations for sobriety will be part of the treatment plan. Substance Abuse Programs will communicate treatment regimens with all of the waiver participant's service providers. All

Substance Abuse Programs must be documented in the service plan and provided by individuals or agencies approved as providers of this waiver service. Provider qualifications are specified in Appendix B-2.

Transitional Living Services: Individualized short-term services designed to improve the waiver participant's skills and ability to live in the community when the waiver participant is unable to be supported in a permanent residence and is in need of intensive clinical interventions. Transitional Living Services include assessment, training, supervision of and assistance to an individual with self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, problem-solving skills, money management and ability to maintain a household. These services include a residence for a short duration, with up to 24-hour supervision and support and interventions designed to assess and improve the waiver participant's ability to live in the community as independently as possible. The Transitional Living Services provider is responsible for assisting the waiver participant and the Department of Social Service's social worker in identifying a permanent residence and support system in the community.

Transitional Living Services differ from other available services in several significant ways. These services are expected to meet all of the waiver service and support needs of the participant. The only other waiver service available to the waiver participant during provision of these services is Case Management. Medicaid State Plan services, such as physical or occupational therapy, may also be accessed while utilizing these services. Prior to completing Transitional Living Services the DSS social worker will develop the community services plan of care in conjunction with the provider and the waiver participant. When the participant moves from this service to living more independently in the community, other waiver services will be approved. It is anticipated that this service will be provided only one time to any individual participant.

All Transitional Living Services must be included in the service plan and provided by agencies approved as a

provider of this waiver service. No portion of Medicaid funds are allocated for the room-and-board component of this service. Provider qualifications are specified in Appendix B-2.

Vehicle Modifications: are physical modifications made to a motor vehicle to improve the waiver participant's independence and inclusion in the community when they are deemed necessary to prevent institutionalization. Modifications may be made to the vehicle which is the waiver participant's primary means of transportation. The vehicle may be owned by the waiver participant, by family members with whom the participant lives or has consistent and ongoing contact, or by a non-relative who provides primary long-term support, but is not a paid service provider, to the participant.

All vehicle modifications must be included in the service plan and provided by agencies approved as a provider of this waiver service. Provider qualifications are specified in Appendix B-2.

t._____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other State plan services (Specify):

u._____ Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this

service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

ATTACHMENT B-1 Service Definition

Case Management/Service Coordination

The Department of Social Service's (DSS) Social Worker, who acts on behalf of the Medicaid Agency, will be the Administrative Coordinator. He/she must have a thorough knowledge of all the other services available through this waiver, as well as all the services and supports available through the regular State Medicaid program, and from all other state and federal funding. Sources of informal support are often the crucial determining factor if the waiver participant is to live a satisfying life, and remain

in the community. The service coordinator's ability to make use of these informal supports is essential, and provides the greatest opportunity for creativity. Therefore, the service coordinator and the social worker must work closely together.

Department of Social Service's Social Worker Responsibilities/Administrative Functions

The Department of Social Service's Social Worker will also be responsible for:

1. completing an initial assessment and developing the service plan;
2. formally reviewing the Service Plan at least every twelve months;
3. maintaining records for at least three years;
4. assuring that the assessment of need for a nursing facility level of care will be initiated on the anniversary of the initial determination;
5. initiating a re-evaluation of the level of care when the waiver participant has experienced a significant improvement in his/her ability to function independently in the community, and in the professional judgment of the waiver service coordinator, may no longer meet the institutional level of care criteria.

***** All Waiver participants receive this service*****

The key to individual choice and satisfaction is person-centered service coordination. Programmatic service coordinator is a purchaseable service. Waiver participants will receive this service only if they are unable to co-ordinate their own plans or do not have family or natural supports to act in this role, under circumstances which may include one or more of the following: crisis intervention and monitoring; after-hours availability; when the conservator, family member(s) or other natural supports are out-of-state or are not available to fulfill this function; if assistance is required to identify, locate and coordinate the hiring and scheduling of multiple individual and/or private waiver service providers; when it is clinically unsound for the conservator and/or family or other natural supports to provide such service.

The service coordinator:

- responds to the individual by helping the participant to identify his or her unique wishes and needs;
- promotes activities which will increase the individual's independence and life satisfaction through participation in meaningful activities;
- assists in the inclusion of the individual in the community of his/her choice;
- arranges for daily living supports and services to meet the individual's needs, including assistance in accessing entitlements and other funding sources;

- provides advocacy for participant to receive needed services, not for ABI population as a whole;
- convenes crisis intervention service planning and monitors when appropriate.

Throughout his/her involvement with the waiver participant, the service coordinator will support and encourage the waiver participant to increase his/her ability to problem solve, be in control of life situations, and be as independent as possible. This is balanced by the need to assure the waiver participant's health, safety, well-being and inclusion in the community. The waiver participant must be included in the decision-making process leading to the plan of care development. The DSS social worker, acting as administrative coordinator, will complete an initial assessment, evaluate the level of care and, with the waiver participant, develop the service plan. If service coordination is identified in the plan as a needed service, the service coordinator will oversee the plan implementation. Individuals for whom service coordination is not a needed service will have family, natural supports or themselves to oversee plan implementation. The DSS social worker will not act as programmatic service coordinator.

Following the approval of the Service Plan, the service coordinator will assist the waiver participant with implementation of the plan. The implementation of each Service Plan will be unique; roles and responsibilities will be determined based on the needs and abilities of the waiver participant. The service coordinator is responsible for assuring that there is adequate coordination, appropriate communication, and maximum cooperation between all sources of support and services for the waiver participant. The ultimate responsibility for assuring that the Service Plan is appropriately implemented rests with the Department of Social Service's Social Worker.

The waiver participant and service coordinator will consistently review the effectiveness of the plan, focusing on the waiver participant's satisfaction as the primary measure of quality. The revision of the Service Plan may occur when the waiver participant requests a change in provider or services received, the expected outcomes are not realized, there is a change in the waiver participant's capabilities, or there is a change in the availability of supports and service.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation and State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Case Management	Agency Provider		Commission on Accreditation of Rehabilitative Facilities (CARF) **OR**	Employ licensed Soc Certified Rehabilit and/or Certified Ca The agency employee case-management ser Master's Degree in Rehabilitation or S year's experience p coordination to per disabilities and kn community resources Degree and two year
	Rehabilitation Hospital Outpatient Department		Joint Commission on Accreditation of Health Organizations (JCAHO)	
	Social Worker	State of CT Department of Health Services CGS Chap. 383b, §20-195m		One year's experien service coordinatio disabilities and kn community resources

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Case Management				

(continued)				
	Certified Rehabilitation Counselor		Commission on Rehabilitation Counselor Certification	Same as above
	Certified Case Manager		Commission for Case Manager Certification	Same as above
	Individual Provider			Person with a Maste Psychology, Rehabil Work and one year's providing service c persons with disabi knowledge of commun person with a Bache two years of the ab

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Homemaker Homemaker (continued)	Home Care Agency			Regulations of CT State Age 17-134-165 Homemaker services provider or regulated. Services sha by any person who is a rela participant, is the partici or is a member of the conse A homemaker service provide • Be at least 18 years of a • Be able to follow writte instructions given by the consumer's designee • Have the ability or skil meet the consumer's n delineated in the ser • Be able to function as a interdisciplinary team • Demonstrate the ability t cognitive behavioral inte
	Individual			Same requirements as above

	Provider			

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Care Assistance	Individual Provider			The person providing person must: • Be at least 18 years of a • Not be the spouse or par consumer is under age 21 the consumer's conservato the conservator's family • Be able to follow written instructions given by the consumer's designee • Have the ability or skil meet the consumer's needs the service plan • Verify completion of tra acquired brain injury, re State agency, a broker ag provider, the Brain Injur CT or an Independent Livi • Receive instruction/train consumer or his/her desig personal care services de service plan • Be able to function as a interdisciplinary team • demonstrate the ability t cognitive behavioral inte • be able to handle emerger

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Respite	Agency Provider		Commission on Accreditation of Rehabilitation Facilities (CARF) – Community Support Services **OR**	Employ staff who: • are at least 18 years of • demonstrate the ability t and healthy living enviro • complete training concern injury, given by a State agency, the Brain Injury Conn. or an Independent L • demonstrate knowledge of

				• demonstrate knowledge of and other emergency situa • demonstrate ability to in and behavioral interventi • demonstrate ability to fu of an interdisciplinary t
	Individua l Provider			The person providing respit meet the same requirements above

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Pre-Vocationa l Services	Agency Provider		Comm. on Accreditation. Of Rehabilitation Facilities (CARF) – Employment Services **OR**	Meets the requirements of C 10-102-9

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Supported Employmen t	Agency Provider		Commission on Accreditation of Rehabilitation Facilities (CARF) – Employment Services **OR**	Meets the requirements of C 14(a)(13)

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Environ-mental Accessibi lity	Private Contracto r or Business			• State Building Code • CGS §10-102-17 and §10-10 • Home Improvement Registra

lity Adaptations	Business			Department of Consumer Pr

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Transportation	Private Transportation Service			Department of Social Servic Medicaid Transportation Pro
	Individual Provider			• Valid Connecticut driver • Proof of I

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Specialized Medical Equipment and Supplies	Private Vendors Who Sell Medical, Communication or Assistive Devices and Supplies, and/or DME			Meets the requirements of C Regulations, Section 10-102-3(e)(8) Department of Administrativ of Purchases/Purchasing Ma Direct Purchase Activity No (CGS 4a-50 and 4a-52)
	Pharmacies	State of CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerni		

		ng Practice of Pharmacy Section 20-175-4-6-7		

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Chore Services Chore (continued)	Home Care Agencies			Regulations of CT. State Ag 17-134-165 Chore service providers are regulated. Services shall any person who is a relativ participant, is the partici conservator, or is a member conservator's family. A chore service provider sh • be at least 18 years of health • have the ability to read instructions • be able to report change condition or needs to th the access agency • maintain confidentiality • complete required recor employer of contractor o
	Individual Providers			Same as above

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Emergency Response Systems	Private Vendors Who Sell and			Regulations of CT. State Ag 17-134-165 Providers shall:

	Install Appropriate Equipment			• provide trained emergenc a 24-hour basis • have quality control of • provide service recipien training • assure emergency power f other safety features • conduct a monthly test o assure proper operation • recruit and train commun responders in service pr • provide an electronic me response system to emerg psychiatric services, po support systems
SERVICE	**PROVIDER TYPE**	**LICENSE**	**CERTIFICATION**	**OTHER STANDARD**
Companion Services	Home Care Agencies			Regulations of CT State Age 17-134-165 Companion service providers or regulated. Services sha by a person who is a relati participant, is the partici or is a member of the cons A companion service provide • be at least 18 years of • be of good health • have ability to read, wr instructions • be able to report change condition or needs to th the access agency • maintain confidentiality • complete required recor employer of contractor o • have completed training concerning acquired brai person-centered planning agency, broker agency, c Brain Injury Association Independent Living Cente
	Individual Providers			Same as above

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Community Living Support Services	Agency Provider		Commission on Accreditation of Rehabilitative Facilities (CARF), Community Support Services **OR**	Rehab. Act 29 USC Sectior Sect. 721 (a)(6)(B) Residence must meet all p State Building Code, fire safety and construction s Employ staff who: • are at least 18 years • demonstrate the abilit safe and healthy livin • complete training conc brain injury given by broker agency, communi Injury Association of Independent Living Cen • demonstrate knowledge • demonstrate knowledge and other emergency si • demonstrate ability to cognitive and behavior • demonstrate ability to member of an interdisc
	Rehabilitation Hospitals		JCAHO/CARF application on file for certification in community support service and/or brain injury community integrated services **AND**	Residence must meet all p Connecticut State Buildir prevention, safety and co standards

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Home-Delivered Meals	Private Agencies			Pursuant to the Regulatio State Agencies, Section 1 provider must provide mea minimum of one-third of t recommended dietary allow requirements established Nutrition Board of the Na Sciences – National Resea

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Independent Living Skills Training and Development	Agency Providers		CARF certification in Brain Injury and/or Community Support **OR**	Employ staff who: • are at least 18 years • have a minimum of a Ba one year's experience to individuals with di community or completed program(s) concerning injury and person-cent given by state agency, community provider, Br Association of CT or a Living Center; **or** • have a high school dip experience providing s individuals with disab community or completed program(s) concerning injury and person-cent given by state agency, community provider, Br Association of CT or a Living Center • demonstrate ability to member of an interdisc • demonst impleme cogniti interve

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Independent Living Skills Training and Development (continued)	Rehabilitation Hospital Outpatient Department		JCAHO	
	Individual Provider			• at least 18 years of a • have a minimum of a Ba one year's experience to individuals with di community or completed program(s) concerning injury and person-cent given by state agency, community provider, Br Association of CT or a Living Center; **or** • have a high school dip experience providing s individuals with disab community or completed program(s) concerning injury and person-cent given by state agency, community provider, Br Association of CT or a Living Center • demonstrate ability to member of an interdisc • demonstrate ability to cognitive/behavioral i

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Cognitive Behavioral Programs	Agency Providers		CARF certification in Brain Injury **OR**	Employ neuropsychologists psychologists, psychologi therapists, speech therap therapists who meet the s below *
	Rehabilitation Hospital Outpatient Department		JCAHO	*
	Neuro-Psychologist	State of CT. Dept. of Health Svcs. Chap. 383B, Section 20-188-1 **AND**		Post-doctoral study or cl in neuropsychology *
	Educational Psychologist		Certified in Special Education **AND**	Ph.D. in Education with c cognitive strategy develo remediation and/or post-d in providing such Services *

* All providers must demonstrate ability to work in a community setting and facilitate an interdisciplinary team.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Cognitive Behavioral Programs (continued)	Psychologists	State of CT Dept. of Health Services Chap. 383B, Sec. 20-188-1 **AND**		At least three year's ex cognitive/behavioral pro with brain injury, deliv settings *
	Occupational Therapist	State of CT Dept. of Health Services Chap. 376, Sec. 20-74i-1 **AND**		At least three year's ex cognitive/behavioral pro with brain injury, deliv settings *
	Speech Therapist	State of CT Dept. of Health Services, Chap. 399, Section 20-408 **AND**		At least three year's ex cognitive/behavioral pro with brain injury, deliv settings *
	Physical Therapist	State of CT Dept. of Health Services Chap. 376, Section 20-66 **AND**		At least three year's ex cognitive/behavioral pro with brain injury, deliv settings *

*All providers must demonstrate ability to work in community setting and to facilitate an interdisciplinary team.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Substance Abuse	Agency Provider		CARF certification	Employ staff with at lea experience in providing

Programs			in Brain Injury **AND**	individuals with substan **OR** Employ certified alcohol counselors or psychologi standards below
	Rehabilitation Hospital		JCAHO **AND**	Staff with at least one in providing services to brain injury and substa
	Substance Abuse Diagnostic and Treatment Centers **AND**	State of CT Health Services (if private facility) **AND**	JCAHO (if public facility) **AND**	Complete training concer injury given by state ag agency, community provid Association of CT or an Center
	Psychologists	State of CT Dept. of Health Services Chap. 383B, Sec. 20-188-1 **AND**		• At least one year's ex assessment and treatme with brain injury and • Ability to develop lin community support prog • Ability to work as a m interdisciplinary tean

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Substance Abuse Programs (continued)	Counselors		Certified Alcohol and Drug Counselor	At least one year's expe assessment and treatment with brain injury and su Ability to develop linka support programs Ability to work as a mem interdisciplinary team

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Transitional Living Services	Agency Provider	State of CT Dept. of Health Services	CARF certification in Brain Injury **AND**	Residence must meet all State Building Code, fir safety and construction

	Rehabilitation Hospital	State of CT Dept. of Health Services	JCAHO **AND**	Residence must meet all State Building Code, fir safety and construction

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Vehicle Modification	Private Contractor or Business			Meets the requirements o CGS 10-102-18(j) and has Motor Vehicles Dealer's

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the

waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_____Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

___X_____ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2.____ SSI recipients (SSI Criteria States and 1634 States).

3.__x__ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.__x__ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6. x The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

x A. Yes ___B. No

Check one:

a.___ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. x Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) x A special income level equal to:

x 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2) x Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1.____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.____ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)__x__**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.__x__ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)__x__ The following percentage of the Federal poverty level:__200 %__

(5)___ Other (specify):

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F._x_ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B._x_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. x The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d) x The following percent of the Federal poverty level:
200 %

(e)___ The following dollar amount
$ ___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

__X__ Other (Specify):
At a minimum, the Department of Social Services' Social Worker, in collaboration with a neuropsychologist who is familiar with the participant. Other qualified individuals will join this interdisciplinary team as appropriate.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months

_____ Every 6 months

__x__ Every 12 months

_____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__x__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___x___ "Tickler" file

_____ Edits in computer system

___x___ Component part of case management*

_____ Other (Specify):

*administrative component performed by Department of Social Services Social Workers

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

_____ By the Medicaid agency in its central office

_____ By the Medicaid agency in district/local offices

_____ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_____ By the case managers

_____ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_____ By service providers

__x__ Other (Specify):
By Department of Social Services' Social Worker at Regional Office

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

___x___ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ATTACHMENT D-3(a)

W-
(Rev.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL
SERVICES

LEVEL OF CARE DETERMINATION: PCA AND ABI WAIVER PROGRAMS

Name of Applicant: _____

SECTION I To Be Completed for PCA and ABI

ADL'	Requires Physical Assistance	Requires Supervision/Cueing (ABI
Bathin	☐	☐
Dressi	☐	☐
Transf	☐	☐
Toileti	☐	☐
Feedi	☐	☐
Tot	_____	_____

☐ Alone ☐ With Spouse ☐ With Dependent Children ☐ With Others (Non-Relatives) _____

Not For PCA Waiver, 2 or more ADL's needing physical assistance required to meet

☐ Apartment ☐ Single-Family ☐ Elderly Housing ☐ Housing for Persons with Disabilities ☐ Other _____ ☐ Boarding House, Rented Room(s) in House ☐ Rooming House

SECTION II *To Be Completed For ABI WAIVER ONLY (Applicant must have an*

Check Applicable

☐ Category I

- ABI
- 2 ADL's (due to physical and/or cognitive deficits)
- Chronic Disease
- Impaired Cognition
- Impaired Behavior (requiring daily supervision) or Cueing
- Mental Illness (pre
- and/or currently in ABI
- 2 ADL's (due to physical deficits)
- Age of Injury Before 22
- Impaired Cognition
- 2 ADL's (due to physical and/or cognitive deficits)
- Impaired Behavior
- Impaired Cognition

☐ Category II

☐ Category III

☐ Category (Chronic Disease

☐ No

☐ No

SECTION III *To Be Completed for PCA and*

Level of ☐ ☐ ☐ ☐ Chronic

DSS **T D-3(b)** **ATTACHMEN**

☐ Refer to ABI Waiver Program:

Catego ☐ ☐ II ☐ III ☐

Number of ADL's Requiring Physical Assistance: ____

Commen

STATE: CONNECTICUT 72 DATE: NOVEMBER 20, 2002

DSS Signature Title Date

W-953
(Rev. 9/96)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

DSS ASSESSMENT FOR ADULT COMMUNITY BASED SERVICES, PCA OR ABI

DATE	SS#	MEDICAID #
FIRST NAME	M.I. LAST NAME	

ENVIRONMENT

LIVING

With Relatives (Not Children)

TYPE OF

How Satisfied Are You with Your Living

If Institutionalized, Do You Want to Return to the

Are Architectural Barriers a

SOCIAL WORKER SHOULD CHECK TO INDICATE ANY EVIDENCE OF THE

- ☐ Environmental Hazards
- ☐ Lack of Cleanliness
- ☐ Living/Sleeping Area Inadequate
- ☐ Kitchen/Bathroom Facilities Inadequate
- ☐ Need Repair
- ☐ Pest Infestation
- ☐ Fire Hazards
- ☐ Other

Explain:

STATE: CONNECTICUT 73 DATE: NOVEMBER 20, 2002

HEALTH

How Is Your ☐ ☐ ☐

Current Health Problems: Specify Current Treatment, Where Treatment Is

Recent History of Hospitalization/Institutionalization: *(Include Dates, Location and Known)*

Past Health Problems: *(Include Physical/Emotional*

Do Your Health Problems Stand in the Way of Doing the Things You

☐ Not at ☐ A ☐ Great

Are You Supposed to Have a Special Diet?

List Medications: Name, Dosage, Frequency *(Include over the counter as well*

HEALTH -

If Applicant or Other Adult or Child in the Household Has Any of the Following Diagnoses, Please Indicate.

	NAME	TREATMENT HISTORY
Acquired Brain Injury		
Alcohol Abuse		
Alzheimer's Disease		
Amputation		
Arthritis		
Blindness		
Cancer		
CVA (Stroke)		
Cerebral Palsy		
Dementia		
Developmental Disabilities		
Diabetes (Sugar)		
Drug Abuse		
Hearing Impaired		
Heart Disease		
Hypertension		
Kidney Failure		
Lead Poisoning		
Liver Disease		
Lung Disease		
Mental Health Condition		
Mental Retardation		
Multiple Sclerosis		
Muscular Dystrophy		
Neuromuscular		
Paraplegia		
Parkinson's Disease		
Quadriplegia		
Spinal Condition		
Visual Impairment		
Other		
Other		

HEALTH -

Additional _____

LIFE PLANNING ACTIVITIES

COGNITI

Can Organize, Plan or Complete

☐ Without Help

☐ With Some Cues from Others

☐ Needs Help But Not Receiving

☐ Who _____

SELF

☐ Is Aware of Strengths and Limitations

☐ Needs Cueing to Be Aware

☐ Who _____

CONCENTRATION/ATTEN

Pays Attention to Conversation or

☐ Without Help

☐ With Some Cues from Others

☐ Needs Help But Not Receiving

☐ Who _____

EMOTIONAL AND BEHAVIORAL ISSUES

Have You Experienced Any Major Life Changes (Crises) in ☐ Yes ☐ No

Identif _____

_____

_____

DO

- ☐ Feel Lonely
- ☐ Have Sleep Problems

ARE YOU:

- ☐ Not Eating
- ☐ Worried, Anxious

WORKER

- ☐ Abusive or Assaultive
- ☐ Wandering
- ☐ Unsafe or Unhealthy Hygiene or Habits
- ☐ Appears Self Centered
- ☐ Threats to Health or Safety
- ☐ Inappropriate Social/Sexual Behaviors
- ☐ Appears Angry Behavior
- ☐ Shaky, Trembling, Crying
- ☐ Depressed Affect
- ☐ Appears Suspicious
- ☐ Poor Judgement
- ☐ Impaired Judgement
- ☐ Suicidal

Comments/Clarificati _____

_____

_____

COGNITIVE

	YES	SOMETIM	NO
Able to	☐	☐	☐
Able to	☐	☐	☐
Oriented to	☐	☐	☐
Oriented to	☐	☐	☐
Short-Term Memory	☐	☐	☐
Distant Memory	☐	☐	☐
Inappropriate	☐	☐	☐
Able to Problem	☐	☐	☐
Able to	☐	☐	☐
Able to Recognize Cues or	☐	☐	☐
Able to	☐	☐	☐

COMMUNICATION

Check Box for Any Member of Household, If

HEARING

☐ Minimal Loss

☐ Moderate

SPECIFIC DEVICE _____

☐ Total Deafness

☐ _____

VISION

☐ Minimal Loss

☐ Moderate

SPECIFIC DEVICE _____

☐ Total Blindness

☐ _____

EXPRESSIVE

☐ Speaks and Is Usually Understood

☐ Speaks But Is Understood Only with Difficulty

Written

☐ Uses Only Gestures

☐ Does Not Convey

RECEPTIVE

☐ Usually Understands Oral Communication

Communicatio

☐ Understands by Depending on Lip Material or Sign

☐ Understands Only Gestures, Environmental

RISK INDICATORS

RISK

☐ Inadequate Supervision

☐ Socially Isolated

☐ Unable to Summon

FINANCIAL

☐ Mismanagement of Funds

☐ _____

WORKER

EVIDENCE OF PHYSICAL

☐ Poor Hygiene

☐ Fleas, Lice

☐ Skin Breakdown (Rashes, Sores)

☐ Inadequate Food, Weight Loss

☐ Malnutrition

☐ Inappropriate Dress

☐ Fecal, Urine Odor

☐ Untreated Medical Condition

☐ Alcohol Abuse

☐ _____

FUNCTIONAL ASSESSMENT

Activities of Daily Living	Completely Able	Able with Help/Device	Completely Unable	Who Assists?
Bathing				
Dressing/Undressing				
Eating				
Toileting				
Bladder Continence				
Bowel Continence				
Getting In/Out of Bed				
Getting Around Inside				
Stair Climbing				
Wheeling				
Grooming/Hygiene				

Instrumental Activities of Daily Living	Completely Able	Able with a Little Help	Able with a Lot of Help	Completely Unable	Who Assists?
Meal Preparation					
Light Housework					
Laundry					
Shopping					
Taking Medicine					
Getting Around Outside					
Transportation					
Money Management					
Telephone Use					
Care/Supervision of					
Life Skills					

Other - *Please* _____

_____

_____

_____

Have You Ever Directed Someone to Provide You with Self Care? _____

_____

_____

Is Training Necessary for ☐ Yes ☐ No

Do You Use Prosthetic

☐ Motorized Scooter ☐ Cane ☐

☐ Motorized ☐ ☐ _____

FUNCTIONAL ASSESSMENT -

Commen _____

_____

_____

_____

_____

_____

_____

Is Person Capable of Directing ☐ Yes ☐ No

COMMUNITY BASED SUPPORTS

W-1035
(Rev. 8/98)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT ACQUIRED BRAIN INJURY PERSONAL CARE ASSISTANCE
HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVERS

Please Think of Your Relatives *(besides those who live in this house/apartment)* **to Whom You Feel Close: Your Children, Brothers, Sisters, Spouse or Other Relatives. What Are Their Names and Their Relationship to You?**

NAM	RELATIONS	TELEPHO

Do You Have Any Friends or Neighbors Who Would Be Available If ☐ Yes ☐ No

Identif _____

_____

_____

Who Is Your Main Supporter? _____

Is This Person's ☐ ☐ ☐

Describe Person's Back-Up Plan for Situations When Regular PCA's Are

_____

_____

_____

_____

_____

_____

STATE: CONNECTICUT 80 NOVEMBER 20, 2002

FREEDOM OF CHOICE/HEARING NOTIFICATION

I,_____, have been informed that I am eligible for care provided through:

* long term care institutions

or

* Home and Community Based Services

I have ☐ chosen ☐ not chosen Home and Community Based Services.

I acknowledge the risk that is inherent in living in the community and I accept full liability for that risk.

Appeal Information

If you do not agree with the plan of services offered by the social worker, you have the right to appeal and request a hearing ***within 60 days from the date of this notice.*** A request for a hearing must be made in writing and addressed to:

State of Connecticut
Department of Social Services
Administrative Hearings and Appeals
25 Sigourney Street
Hartford, CT 06106-5033

I further understand that if I believe I have been treated unfairly because of age, race, color, religion, creed, marital status, national origin, sex or physical disability, including but not limited to, blindness or mental retardation, I have the right to appeal to the Commissioner of the Department of Social Services, the Commission of Human Rights and Opportunities or the U.S. Department of Health and Human Services.

If you have further questions feel free to contact your social worker.

_____	_____
Consumer or Conservator Signature	*Date*
_____	_____
Witness if Consumer Signs with an "X"	*Date*
_____	_____
Typed or Printed Name of Witness	*Date*
_____	_____
Department of Social Services Social Worker	*Date*

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

ESTADO DE CONNECTICUT
DEPARTAMENTO DE SERVICIOS SOCIALES

DAÑO CEREBRAL ADQUIRIDO CONNECTICUT/AYUDA CON CUIDADO PERSONAL
RENUNCIAS DE MEDICAID DE SERVICIOS AL HOGAR Y CON BASE EN LA COMUNIDAD

LIBERTAD DE ESCOGER/NOTIFICACION DE AUDIENCIA

Yo,_____, he sido informado(a) que yo soy elegible para cuidado provisto a través de:

* instituciones de cuidado para largo período

o

* Servicios al Hogar y con Base en la Comunidad

Yo he ☐ escogido ☐ no escogido Servicios al Hogar y con Base en la Comunidad.

Reconozco el riesgo que es inherente en vivir en la comunidad y acepto la entera responsabilidad para el riesgo.

Información para Apelar

Si usted no está de acuerdo con el plan de servicios ofrecido por el/la trabajador(a) social, usted tiene el derecho de apelar y solicitar una audiencia ***dentro de 60 días desde la fecha de este aviso.*** Una solicitud para una audiencia debe ser hecha en escrito y dirigida a:

State of Connecticut
Department of Social Services
Administrative Hearings and Appeals
25 Sigourney Street
Hartford, CT 06106-5033

Yo entiendo además que si yo creo que he sido tratado(a) injustamente debido a edad, raza, color, religión, credo, estado marital, origen nacional, sexo o incapacidad física, incluyendo pero no limitado a, ceguera o retardación mental, yo tengo el derecho a apelar al Comisionado del Departamento de Servicios Sociales, la Comisión de Derechos Humanos y Oportunidades o el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Si usted tiene más preguntas sientase libre de comunicarse con su trabajador(a) social.

_____	_____
Firma del Consumidor(a) o Conservador	*Fecha*
_____	_____
Testigo si Consumidor(a) Firma con una "X"	*Fecha*
_____	_____
Nombre en letra de Molde o Estampado del Testigo	*Fecha*
_____	_____
Trabajador(a) Social del Departamento de Servicios Sociales	*Fecha*

ESTA INFORMACION ESTA DISPONIBLE EN DIFERENTES FORMAS. TELEFONO (800) 842-1508 O

TDD/TTY (800) 842-4524.

ATTACHMENT D-4(a)

ATTACHMENT D-4(b)

At the time of the screening for eligibility to participate in this waiver, the social worker will inform the potential participant of his or her option of receiving services in a long-term care institution or through this waiver. The individual will also be advised of his/her right to a Fair Hearing. This will be documented on the "FREEDOM OF CHOICE/FAIR HEARING NOTIFICATION" form attached. This form will be maintained by the administrative coordinator in the participant's case file. A list of those individuals choosing institutional care will be maintained by the ABI Waiver Coordinator.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Forms are maintained by the Department of Social Services in the district/local offices.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

__x__ Social Worker (qualifications attached to this Appendix)

_____ Case Manager

_____ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

_____ By case managers

_____ By the agency specified in Appendix A

_____ By consumers

__x__ Other (specify):
Department of Social Services regional offices

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

__x__ Every 12 months

_____ Other (specify):

Job Specifications Detail
Classified/Competitive
Class Code Pay PlanClass Title

7713 SH – 24 SOCIAL WORKER - SOCIAL AND HUMAN SERVICES

PURPOSE OF CLASS:

In a state agency or institution this class is accountable for the provision of intensive supportive social case work services to an assigned caseload of individuals and families.

SUPERVISION RECEIVED:
Works under the general supervision of a Social Work Supervisor or other employee of higher grade.

SUPERVISION EXERCISED:
May lead professional and clerical staff as assigned.

EXAMPLES OF DUTIES:
Performs a variety of highly skilled case work services; obtains medical, physical and social histories of clients in order to provide maximum services to individual; confers with clients, relatives, professional associates and other social welfare agencies regarding case problems; provides counseling services to an assigned caseload; provides services to aged and disabled clients in boarding or convalescent homes; conducts and interprets results of investigations, professionally evaluating their significance; seeks employment, housing, financial assistance and other services for an assigned caseload; independently prepares case histories, forms and reports; performs related duties as required.

DEPARTMENT OF CHILDREN AND FAMILIES: Performs a variety of highly skilled case work services for children and youth; maintains medical, physical, social and psychological histories; counsels families, children and youth both individually and in groups; investigates, evaluates and makes recommendations for Juvenile Court on all petitions alleging neglect or abuse of children; recruits and selects foster and adoptive homes for placement of children; consults with psychologists, psychiatrists and other staff to develop and administer treatment plans; consults with community groups to determine appropriate referrals and develop community resources; may supervise volunteer workers in conjunction with department volunteer services programs; performs related duties as required.

EXPERIENCE AND TRAINING:
Considerable knowledge of principles, techniques and methods of professional social work; considerable knowledge of various economic, emotional, medical, psychological and social factors influencing attitudes and behavior of individuals and families; knowledge of community resources available to individuals and families; considerable interpersonal skills; considerable oral and written communication skills; considerable ability to interpret and apply social work policies; considerable ability to prepare clear and concise reports and case histories.

General Experience:
A Master's degree in social work or a closely related field or a Bachelor's degree in social work or a closely related field and two (2) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning or a Bachelor's degree and three (3) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning.

Substitution Allowed:
For state employees successful completion of the Social Worker Trainee program may be substituted for the General Experience.

SPECIAL REQUIREMENTS:

1. Incumbents in this class may be required to speak a foreign language.
2. Incumbents in this class may be required to travel.

NOTES:
1. Closely related fields are: applied sociology, child development, child welfare, clinical psychology, counseling, human development and family relations, human service, marriage and family therapy, nursing social and/or human services.

☐ Nursing ☐ Divert ed ☐ De-Institutionalized ☐ Chronic Disease

2. DEPARTMENT OF CHILDREN AND FAMILIES: A degree in a closely related field is required. Any candidate lacking a degree in a closely related field will require approval of credentials by the Department of Children and Families Court Monitor.

☐ of ☐ of

3. DEPARTMENT OF CHILDREN AND FAMILIES, BUREAU OF JUVENILE JUSTICE: A degree in criminal justice will be accepted as a closely related field.

4. Qualifying experience at this level includes the use of professional interviewing techniques, provision of skilled counseling to an assigned client caseload and assessment of basic client needs (nutritional, environmental, financial, medical, protective service) through continuing personal observation during home visits.

This replaces the existing specification for the same class in Salary Group SH 23 approved effective March 8, 2002. (Revised to implement evaluation)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL

CONNECTICUT ACQUIRED BRAIN INJURY
HOME AND COMMUNITY BASED SERVICES

SERVICE PLAN

I. General Information

Name		Current	
Date of	Residence upon Waiver		Age of
Phone # ( )	Social Security	Phone # ( )	Medicaid
Conservator (if Nam Phon		DSS Social Nam R. Phon ( )	

II. Individual's Preferences and Plans for Living Situation, Meaningful Daily Activities and Social Activities

Living

Meaningful Daily

II. Individual's Preferences and Plans for Living Situation, Meaningful Daily Activities and Social Activities *(Continued)*

Social _____

III. Current Profile of the Individual's Abilities and Supports

Activities of Daily Living (e.g., dressing, _____

Instrumental Activities of Daily Living (e.g., banking, _____

Mobilit _____

Behavioral _____

Participant Name _____

III. Current Profile of the Individual's Abilities and Supports

Cognitive

Unique Strengths or _____

Unique Weaknesses or _____

Natural Support System (may be current or anticipated prior to _____

-

-

III. Current Profile of the Individual's Abilities and Supports (Continued)

-Community _____

IV. Relevant Pre-Injury Information (Education, Employment, Family and Social Status)

V. Relevant Injury Related and Post-injury Information

VI. Assistance Provided through Natural Supports When Service Plan Is Implemented

VII. SERVICE PLAN RATIONALE

Please list each of the proposed services, followed by the team's reason for selecting the service, the goal(s) expected to be achieved and time frame.

SERVICE TYPE: _____

Rational _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rationale _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rationale _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rationale _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rationale _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rational _____

_____

_____

Goal: _____

Time Frame: _____

Participant _____

SERVICE PLAN RATIONALE

SERVICE TYPE: _____

Rational _____

_____

_____

Goal: _____

Time Frame: _____

SERVICE TYPE: _____

Rational _____

_____

_____

Goal: _____

Time Frame: _____

* *

INSTRUCTIONS FOR COMPLETING SERVICE COSTS

Part A. ABI Waiver Services Costs

Service	Enter the procedure code for each service from the Provider Manual or ABI Rate
Name of	Enter the name of each service selected.
Name of	
# of	Number of months service will be provided (if one-time service, e.g., vehicle
Provider	Indicate provider type: A = agency, P = private
# of Units per	List number of units per month (use units on Rate Schedule, monthly total = weekly
Unit	List unit rate (use Rate Schedule or negotiated rate, whichever is less).
Monthly	=
Yearly	Indicate monthly total for service. (monthly total = weekly total x 4.33)
Tota	

Part B. Service Plan Expenditures By Month For 12 Month Period

This chart is to let the fiduciary agent know when a change is planned.

a. Start with the first month that plan is to be implemented. Indicate total monthly cost of all services to be funded.

c. If there is a change in plan for any subsequent month,

d. If there is a one-time service planned (e.g., vehicle modification), add costs to

Part C. Non-Waiver Services/Costs

This block is to be used to list the countable non-waiver services and their

VIII. Services Provided through Waiver Funding --Please describe the ABI services requested and complete the following chart.

Service	Provider	# of Units per Month	Unit Rate	Monthly Total	Yearly Total

PART A. ABI WAIVER SERVICES

Service Code	Name of Service	Name of Provider	# of Months	Provider Type	# of Units per Month	Unit Rate	Monthly Total	Yearly Total
TOTAL								

PART B. MONTHLY SERVICE PLAN COSTS FOR THIS 12

Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.

PART C. NON-WAIVER

Home Health Care					
Nursing Services					
Physical Therapy					
Speech Therapy					
Occupational Therapy					
Other State Funded/Administered*					
Other State Funded/Administered*					

TOTAL	

*Other involves services (essential services, BRS or other non-Medicaid) provided by the Department other than those provided by the waiver, and all services provided by programs administered by any other state

D. PROJECTED TOTAL COST OF WAIVER $_____

E. PROJECTED TOTAL COST OF NON-WAIVER $_____

F PROJECTED TOTAL COST OF $_____

G. PARTICIPANT'S APPLIED

I understand that because my income is more than 200% of the federal poverty level (FPL), I must pay this excess amount monthly toward the cost of my ABI Waiver Services. This is called my applied income.

Total Monthly Gross $ _____

Minus 200% of $ _____

MONTHLY APPLIED INCOME $ _____

I will pay this amount

IX. Signatures

Part A. RO Original

Waiver Participant _____ Date _____

Conservator/Representative _____ Date _____

DSS Social Worker _____ Date _____

Supervis _____ _____

Part B. CO Approval of Original

☐ This plan of care is approved as written.

☐ This plan of care needs to be revised before it can be

Specific areas of _____

_____

_____

_____

Waiver Coordinator or Designee _____ Date _____

Part C. RO Revision of ☐ **Original** ☐ **Active**

DSS Social _____ Date _____

Supervisor _____ Date _____

Part D. CO Approval of Revised

APPENDIX E-2

☐ This plan of care is approved as written.

☐ This plan of care needs to be revised before it can be

Specific areas of _____

_____

_____

Waiver or Designee _____ Date _____

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Existing Department of Social Services'(DSS)social work staff are designated in each of the Department's five regions to work with individuals with ABI who are determined to be eligible for the waiver. Plans of care will be located at the regional offices of the Department of Social Services and will be available upon request to the Medicaid unit. Since the Department of Social Services' social workers are in the same agency as the Medicaid unit, review and approval of the plans of care will be delegated to regional supervisory staff. Should problems arise, the waiver coordinator and Medicaid liaison retain the authority to make the final decision regarding plans of care.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

ATTACHMENT E-2

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

___x___ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

_____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

_____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   ___x___ Yes

   _____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   ___x___ All claims are processed through an approved MMIS.

   _____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

__x__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

__x__ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

ABI RATE SCHEDULE

Waiver Services

Proc. Code	Description of Service	Max Service Am't	Unit
1530P	Case-Management	12 hrs/day	Hour
1532P	Chore (Agency)	8 hrs/day (32 units)	Qtr. Hour
"	Chore (Private)	"	Qtr. Hour
1534P	Community Living Support Services (CLSS)	2/day	Half day
1536P	Companion Services (Agency)	18hrs/day (72 units)	Qtr. Hour
"	Companion Services (Private)	"	Qtr. Hour
1538P	Environmental Accessibility Adaptations	$10,000 units/year	$10,000/year
1542P	Homemaker Services (Agency)	8 hrs/day (32 units)	Qtr. Hour
"	Homemaker Services (Private)	"	Qtr. Hour
1546P	Independent Living Skill Development (Indiv.)	12 hrs/day	Hour
1548P	Cognitive/Behavioral Programs	4 hrs/day	Hour
1550P	Home-Delivered Meals (single)	Single only/day	
1551P	Home-Delivered Meals (double meal)	Double only/day	
1554P	Personal Care Assistant (private only)	18 hrs/day (72 units)	Qtr. Hour
1556P	Personal Emergency Response System (PERS)	One-time install	
1557P	Personal Emergency Response System (monthly service)	2/mo	1-way
1560P	Pre-Vocational Services	40 hrs/week	Hour
1562P	Respite Care	24 hrs/day	Hour
1564P	Specialized Medical Equipment & Supplies	$ value/year	$ value/year
1566P	Substance Abuse Program (daily)	56 days/year	Day
1567P	Substance Abuse Program (hourly)	4 hrs/day	Hour
1572P	Supported Employment	40 hrs/week	Hour
1574P	Transportation (Public)	4 trips/day	1-way trip
1575P	Transportation (Mileage--Private)	999 miles/day	Mile

1578P	Vehicle Modification	$ value/year	$ value/year
1580P	Transitional Living Services	183 days/year (1x only)	Day